



# State of Maine

DEPARTMENT OF STATE

BUREAU OF MOTOR VEHICLES

AUGUSTA, MAINE 04333

## DRIVER MEDICAL EVALUATION

THIS IS THE ONLY MEDICAL REPORTING FORM THAT WILL BE ACCEPTABLE TO THE BUREAU OF MOTOR VEHICLES.

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

TELEPHONE # \_\_\_\_\_

### CERTIFICATE OF EXAMINATION

#### FOR THE REPORTING PHYSICIAN:

1. This report is requested because the issue has been raised as to the possibility that this applicant may have a mental/physical condition which could affect his/her ability to drive a motor vehicle safely. Your report will be advisory and used to assist in determining eligibility for a driver's license. If you have any questions, please call the Medical Review Coordinator's office.
2. A physician acting in good faith is immune from any damages claimed as a result of the filing of a certificate of examination pursuant to 29-A MRSA Section 1258 (6).

#### FUNCTIONAL ABILITY PROFILE

This form cannot be completed without reference to the Functional Ability Profiles Booklet\*

DIAGNOSIS  
(PLEASE PRINT OR TYPE)

If COPD, need 02 Sats.

PROFILE LEVEL  
THIS SECTION MUST BE COMPLETED,  
CHECK ONLY ONE BOX PER DIAGNOSIS

1.	2.	3.				4.
		A	B	C	D	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of last examination \_\_\_\_\_ How long has applicant been your patient? \_\_\_\_\_

must be within past year

For seizures or loss of consciousness give date of most recent episode \_\_\_\_\_

Current prescribed medication(s): \_\_\_\_\_

☐ No medication prescribed

Reliability in taking medication

Good ☐ Fair ☐ Poor ☐ Unknown ☐

Has this patient demonstrated any side effects from current medication(s) which would interfere with safe operation of a motor vehicle? \_\_\_\_\_

\*A copy of which can be obtained by calling (207) 624-9000, ext. 52124, fax no. (207) 624-9319.

[illegible]

**AUTHORIZATION FOR RELEASE**  
 I authorize the release of my medical history to the Secretary of the State of Michigan for a driver's license by:  
 \_\_\_\_\_  
 Patient

[illegible]

Patient \_\_\_\_\_

Patient \_\_\_\_\_

I hereby certify that I have examined this applicant.

Signature \_\_\_\_\_

Specialty

Physician's Name Printed or Typed

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Address

Office Phone Number \_\_\_\_\_

Date \_\_\_\_\_

Medical Review Coordinator  
Bureau of Motor Vehicles  
29 State House Station

Augusta, Maine 04333-0029  
Telephone: (207) 624-9000, ext. 52124  
Fax: (207) 624-9319